5 MEDICARE BENEFICIARIES IN NURSING HOMES

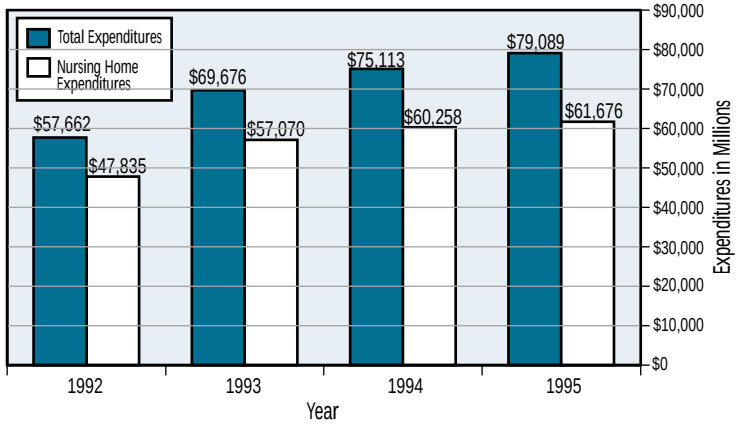
As the number of Medicare beneficiaries age 85 years and older continues to grow, long-term care issues are increasingly the focus of public health policy. One of the strengths of the MCBS is that it provides comprehensive data on Medicare beneficiaries living in nursing homes (NHs), including their personal health care expenditures and financing of health care. This chapter examines the characteristics of Medicare beneficiaries in NHs, the facilities, and the use of health services. It is restricted to Medicare beneficiaries who resided in a long-term care facility for the entire year.[1] The facilities include NHs, domiciliary or personal care facilities, distinct long-term care units in a hospital complex, mental health facilities and centers, assisted living and foster care homes, and institutions for the mentally retarded and developmentally disabled.[2]

Personal Health Care Expenditures

Medicare beneficiaries in NHs are high-cost users of health care services (Laschober and Olin, 1996; Komisar et al., 1997/98). Their personal health care expenditures (PHCE) include room and board expenses, acute and chronic care expenses for inpatient and outpatient medical services, physicians' services, medical supplies, prescription medicines, and other health care related services. In 1995, this group included 2.1 million beneficiaries, or approximately 5 percent of the Medicare population. They consumed $79.1 billion in personal health care, or approximately one-fourth of all personal health care resources used by the Medicare population (Figure 5-1a).

Several factors contribute to the high cost of care for NH residents. Room, board, and nonmedical care services, such as assistance in daily activities like eating, dressing, toileting, and bathing, are the predominant reason. These expenses totaled $62 billion in 1995, or 78 percent of NH residents' PHCE in 1995 (Figure 5-1a). Per capita spending on NH care increased from $25,558 in 1992 to $29,868 in 1995, or 17 percent growth. Nevertheless, the share of NH expenses has been decreasing in recent years (from 83 percent of total expenditures in 1992 to 78 percent in 1995), and the share of non-NH medical expenses is increasing.

Figure 5-1a Personal Health Care and Nursing Home Expenditures by Nursing Home Residents, 1992-1995



Between 1992 and 1995, per capita medical care spending—excluding NH expenses—increased by more than 60 percent for NH residents, from $5,250 in 1992 to $8,433 in 1995. Per capita expenditures by community-only residents grew by about 28 percent during the same period, from $5,053 in 1992 to $6,470 in 1995. These data suggest that much of the growth in per capita PHCE by NH residents is explained by the cost of their non-NH medical care. Figure 5-1b shows the distribution of PHCE by type of service for NH residents. Aside from NH expenses, inpatient hospital care accounted for 8.8 percent of total expenditures by NH residents, followed by medical provider services (6.5 percent), outpatient services (3.5 percent), and skilled nursing facility care (2.3 percent).[3]

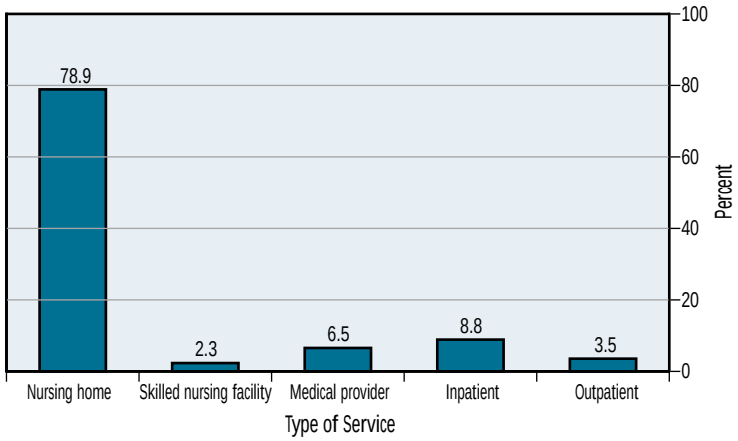
Another contributor to the level of PHCE by NH residents is that their mortality rates are much higher than those of Medicare bene-

1 Beneficiaries who started their nursing home stay in a skilled nursing facility (SNF) but who finished as a full-year resident are also included in this chapter.

2 For convenience, they are all referred to as nursing homes hereafter.

3 Expenditures on prescription medicines are included in room, board, and ancillary charges.

Figure 5-1b Personal Health Care Expenditures by Nursing Home Residents, by Type of Service, 1995



ficiaries living in communities. In 1995, more than 21.2 percent of NH residents died, compared with 3.4 percent of community-only Medicare beneficiaries. These differences in mortality rates are important because it costs significantly more to care for people in their last year of life. For instance, Medicare alone spends 6 times as much in an average year on beneficiaries in their last year of life as it does on beneficiaries who do not die (Kronenfeld, 1993). The MCBS data confirmed that beneficiaries close to death spend more on average than others.

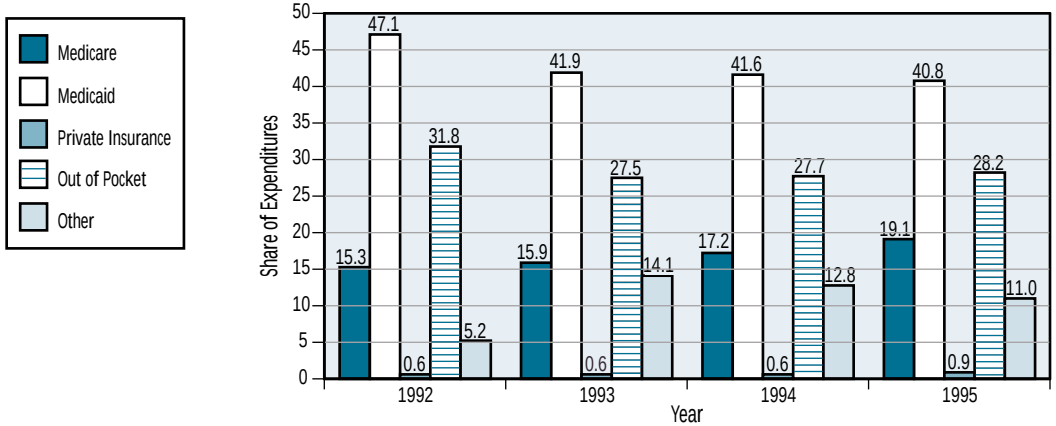
Health care expenditures by NH residents are continuing to grow rapidly. Figure 5-1a shows that personal health care expenditures of NH residents increased by 37.2 percent between 1992 and 1995, or an average annual growth rate of 11.1 percent. NH expenditures alone grew by about 29 percent between 1992 and 1995, or an average annual rate of 8.8 percent. The growth in PHCE for the NH population is caused by increasing numbers of disabled and aged beneficiaries in need of NH care and higher per capita expenditures. The NH population grew from 1.9 million in 1992 to 2.1 million in 1995, an 11 percent increase over 4 years. Per capita expenditures rose from $42,706 in 1992 to $52,276 in 1995 for the disabled NH residents (a 22 percent increase), and $28,905 to $35,704 for the aged (a 24 percent increase).

Even though average annual growth in PHCE by NH residents is comparable to that of the entire Medicare population (10.5 percent), growth in NH expenditures slowed to 2.4 percent between 1994 and 1995. The slowdown coincided with sharp growth in home health care expenditures by the Medicare population. Between 1992 and 1995, these expenditures increased by 92 percent, or an average annual growth rate of 24 percent. This growth occurred as the Federal Government relaxed its policies on home health coverage for the Medicare beneficiaries in the late 1980s, and they began substituting home health care services for institutional care (Ettner, 1993; Moon, 1997). However, this trend is unlikely to continue because the Balanced Budget Act of 1997 revises Medicare payments for home health services, and mandates an interim payment system to control home health spending until a new prospective payment system has been developed (Medpac, 1999).

Financing of Health Care

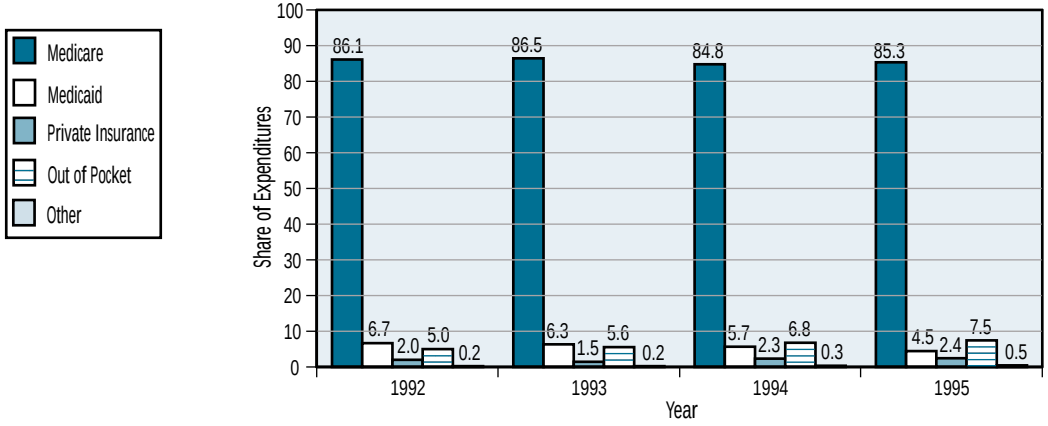
Figure 5-2a shows sources and shares of payment for personal health care by NH residents. Approximately three-fifths of health care expenditures by NH residents is funded by public resources. Even though Medicare does not cover most NH room and board expenses, it does cover medically required services for NH residents. Since NH residents are heavy users of medical services and supplies, Medicare expenditures for this population has been growing rapidly. Between 1992 and 1995, Medicare's share grew from 15 percent to 19 percent of health care expenditures. The total cost to Medicare increased by more than 71 percent, from $8.8 billion in 1992 to $15.1 billion in 1995. Figure 5-2b presents the share of total expenditures by source after excluding NH expenses. Medicare's

Figure 5-2a Sources of Payment for Personal Health Care Expenditures by Nursing Home Residents, 1992-1995



share of expenditures on medical care was about 85 percent of the total during the 1992-1995 period. Per capita cost excluding NH expenses in 1995 for Medicare reached $7,195, an increase of almost 60 percent since 1992.

Figure 5-2b Sources of Payment for Medical Care Received by Nursing Home Residents, 1992-1995



Medicaid is the largest payer of personal health care expenditures for NH residents. In 1995, it paid 41 percent of PHCE by NH residents, or $15,248 per NH resident. These expenditures are high because Medicaid pays for more than 50 percent of room, board, and ancillary NH care expenses for dual eligibles. Moreover, approximately 75 percent of NH residents are covered by Medicaid. A large proportion of them begin their NH stays as Medicaid-eligible, because they had spent down their assets while still in the community or during previous NH stays (Rice, 1989). Other dual eligibles—between 27 and 45 percent of NH residents—spent down while in NHs (CRS, 1993). However, the share paid by Medicaid decreased between 1992 and 1995 as Medicare expanded its coverage of medically required chronic care needs, and beneficiaries substituted home health care for NH care.

NH care creates a heavy financial burden for Medicare beneficiaries and their families. Full-year NH residents finance about 30 percent of their PHCE through out-of-pocket payments (Figure 5-2a). In 1995, out-of-pocket payments by NH residents were $22.3 billion, representing a 22 percent increase from 1992. Per capita out-of-pocket payments for NH expenses alone, excluding other medical expenses, amounted to $10,185 in 1995. However, the proportion of PHCE paid out-of-pocket has been shrinking over time, from 32 percent in 1992 to 28 percent in 1995.

A Profile Of Nursing Home Residents

NH admissions are related to such factors as demographics, socioeconomic status, health status, the availability of informal community help, and the local supply of NH beds (Reschovsky, 1998; Liu, McBride, and Coughlin, 1994; Boaz and Muller, 1994; Feldstein, 1988). Table 5-1 compares NH residents with beneficiaries living in communities. A typical NH resident is an elderly white female with severe functional disability. She is also likely to have limited income and low educational attainment, two characteristics often associated with poor health.

The NH population is much more likely to have more severe functional disabilities. Functional limitation is most frequently the deciding factor why a beneficiary needs institutional care. Moreover, as NH residents get older, they tend to become more frail and disabled. Consequently, more than 90 percent of NH residents had moderate to severe functional disability, compared with 21 percent among community residents. Other crippling health factors, such as mental disorder, also are more prevalent among the NH population. One-third of NH residents were diagnosed as having mental disorder, compared with 7 percent among community residents. These beneficiaries have difficulty performing basic activities of daily living, such as eating, dressing, or bathing.

African-Americans, Hispanics, and other racial and ethnic minorities are under-represented in the NH population. In 1995, racial and ethnic minorities comprised 17.2 percent of community residents, whereas they represented only 12.5 percent of the NH residents. Explanations for the under-representation include discrimination, better family support systems, cultural differences in caring for the elderly, lack of economic means, and a possible lack of knowledge of the available services (Kronenfeld, 1993; Feldstein, 1988). Shorter life expectancies among racial and ethnic minorities are another reason for their under-representation in NHs, since one-half of the NH population consists of beneficiaries who are at least 85 years old.

Dual eligibles, on the other hand, are over-represented in the NH population. In 1995, approximately 75 percent of NH residents were covered by Medicaid, compared with 17 percent of community residents. Several factors contribute to the numbers of dual eligibles in NHs. First, Medicaid eligibility is often indicative of poor health, and chronic conditions or functional limitations. Second, Medicaid eligibility increases NH demand because dual eligibles are insulated from the full cost of NH services. Third, NH residents are more likely than their community counterparts to become eligible for Medicaid because NH expenses quickly deplete their assets.

Table 5-1. Characteristics of Nursing Home Residents and Community Residents, 1995

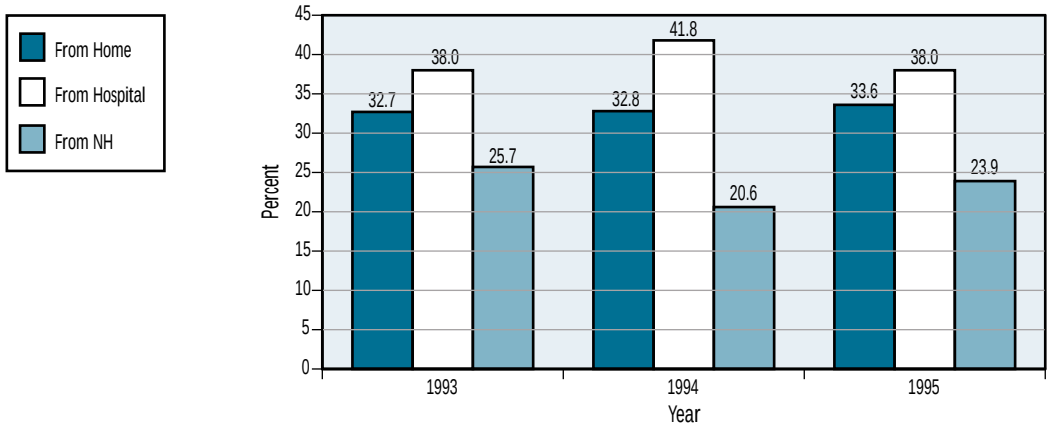
Characteristic	Nursing Home Residents[1] (2.1 million)	Community Residents (36.7 million)
	Beneficiaries as a Percentage of Column Total	
Age		
Under 65 years	15.7	11.4
65 - 74 years	10.9	50.9
75 - 84 years	26.7	29.2
85 years and older	46.7	8.5
Gender		
Male	31.1	44.0
Female	68.9	56.0
Race/Ethnicity		
White non-Hispanic	87.5	82.8
Black non-Hispanic	8.0	9.2
Hispanic	2.6	5.9
Other	1.9	2.1
Income		
Less than $5,000	8.6	4.4
$5,000 - $7,499	37.8	12.6
$7,500 - $9,999	22.9	12.2
$10,000 - $14,999	13.0	17.3
$15,000 or more	17.8	53.6
Health Insurance		
Medicare Only	12.4	12.5
Medicaid	75.3	16.5
Private insurance	12.3	71.0
Functional Limitation		
None	0.0	57.0
IADL only[2]	7.1	21.6
One to two ADLs[3]	19.4	13.2
Three to five ADLs	73.5	8.2

1 Nursing home residents include full-year facility residents only.

2 *IADL* stands for Instrumental Activity of Daily Living.

3 *ADL* stands for Activity of Daily Living.

Figure 5-3 Status at Admission of Nursing Home Residents, 1993-1995



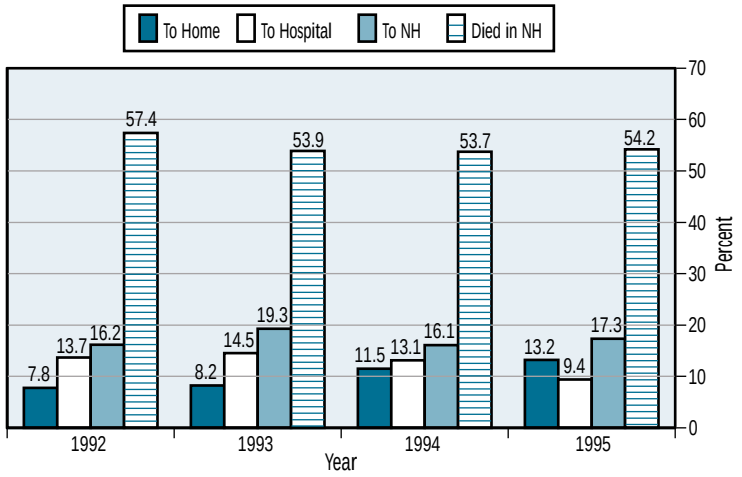
Most beneficiaries stay in a facility until the end of their lives once they are admitted. In any given year, approximately 70 percent of NH residents are continuing their stay from the previous year, and a similar proportion, including admissions during the current year, remain in the same facility at the end of the year.[4] Of the admissions in each year, more than 70 percent of them are from communities, either their home or a hospital; and approximately 25 percent are from other NHs (Figure 5-3). Figure 5-4 presents beneficiaries' status at discharge, which sheds some light on destination of the 30 percent of NH residents who are discharged. Each year, approximately 55 percent of the discharged beneficiaries are those who die in a facility.[5] Another one-quarter of the discharges are residents returning to the community or a hospital. Around 16 to 19 percent of discharges are beneficiaries who move between NHs.

Even though the majority of NH residents stay in the same facility from one year to the next, turnover rates in NHs can be quite high. Of the NH residents starting in 1992, less than one-half of them remained in 1994, and less than one-quarter of them in 1995. Thus, NHs are places of high turnover, where residents are likely to enter or leave due to natural causes, such as diseases or death, or individual decisions, such as moving to a different facility.

Characteristics of Nursing Homes

In 1995, Medicare beneficiaries stayed in a variety of long-term care facilities.[6] Figure 5-5 indicates that 63 percent of the facilities are privately owned, 25 percent are private nonprofit organizations, and the remaining 12 percent are owned by government agencies. This distribution of ownership is similar to data published by HCFA (DHHS, 1997).[7] Seventy percent of the facilities are free-standing NHs; another 10 percent are free-standing mental health care facilities; and 14 percent consist of assisted living facilities, retirement homes, personal care facilities, and rehabilitation centers (Figure 5-6). NHs in the MCBS vary in size, but the tendency is toward larger facilities. Figure 5-7 indicates that more than 60 percent of them are relatively large, with 100 or more beds. Approximately 14 percent of them are relatively small, with fewer than 50 beds.

Figure 5-4 Status at Discharge of Nursing Home Residents, 1992-1995



[4] A longitudinal sample was created to follow movements of beneficiaries in nursing homes by restricting the MCBS data to respondents (1) who were in the sample in 1992 and still living at the end of 1995; and (2) who were in the sample in 1992 and died in 1992 or before the end of 1995.

[5] The mortality rate for NH residents is higher, because this percentage does not count full-year NH residents who died at home or in a hospital.

[6] Because the MCBS sample is selected to reflect the characteristics of the Medicare population, the distribution of facilities probably is not representative of long-term care facilities in the U.S.

[7] The NH chartbook published by HCFA indicates that 66 percent are proprietary, 30 percent voluntary (nonprofit), and 9 percent government owned.

Figure 5-5 Distribution of Nursing Homes by Type of Ownership, 1995

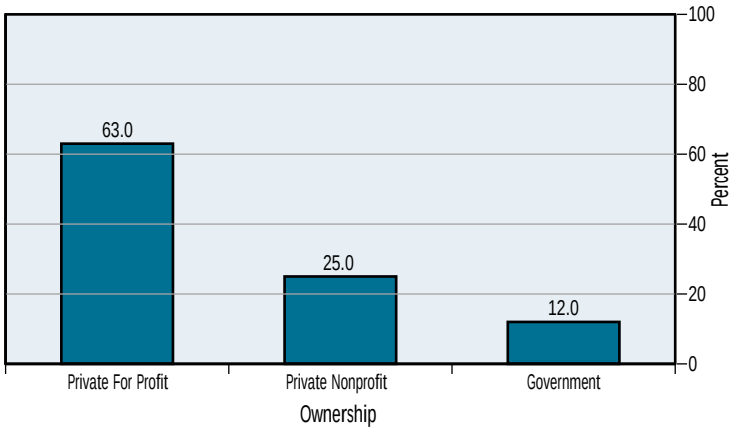
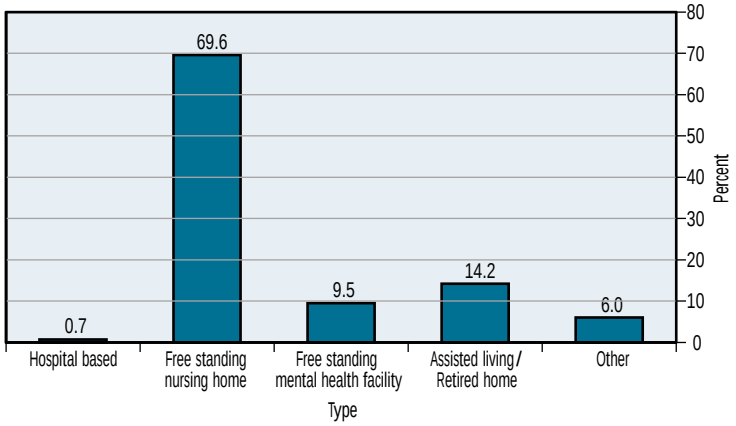
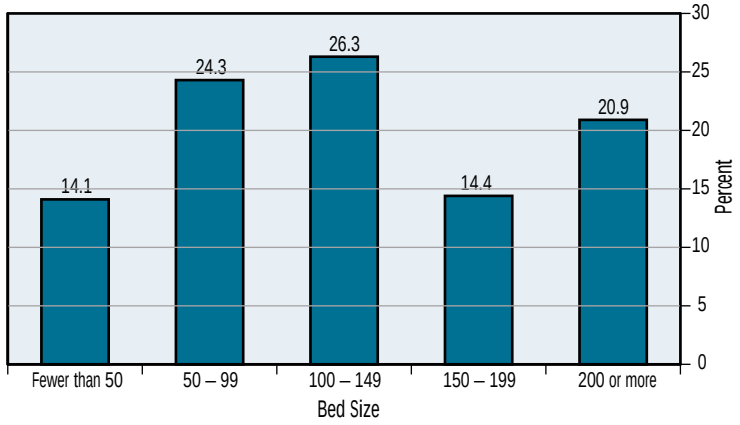


Figure 5-6 Type of Nursing Home, 1995



These NHs, regardless of their ownership, attract large numbers of dual eligibles because Medicaid distorts the demand for and supply of NH beds. By subsidizing the cost of NH care, Medicaid creates a greater-than-optimal demand for NH care by Medicaid eligibles. At the same time, states often have monopoly power over the NH market because Medicaid plays a large role in supporting NHs. This

Figure 5-7 Distribution of Nursing Homes in the MCBS by Bed Size, 1995



enables individual states to set Medicaid reimbursement rates below market rates for private payers, and enforce limits on the supply of NH beds. These combined factors cause excess demand for NH care by Medicaid eligibles in many local markets (Reschovsky, 1996; Ettner, 1993; Feldstein, 1988). It is estimated that for every aged NH resident, there are about twice as many aged community residents who require a similar level of long-term care (Feldstein, 1988; DHHS, 1997).

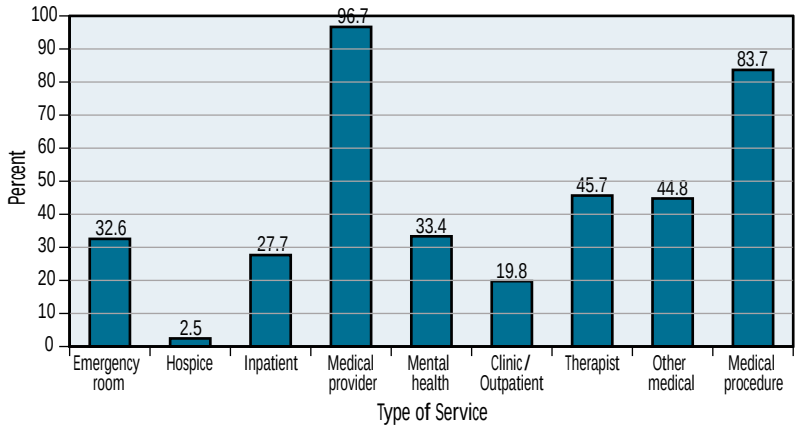
Excess demand for NH care can adversely affect access, particularly for segments of the Medicare population such as dual eligibles and persons in need of chronic care. For example, there is strong evidence that Medicaid eligibility tends to hinder admission to NHs, especially in areas where the markets are tight (Reschovsky, 1996). State-enforced lower reimbursement rates for Medicaid clients give NHs an incentive to admit private patients who will pay full rates. Because of the distortion in prices, Medicaid beneficiaries have a higher probability of being on a waiting list, especially in areas with a high proportion of private payer NH residents and a low bed supply (Ettner, 1993). Thus, the heavy representation of Medicaid eli-

gibles in the NH population does not necessarily indicate good access to NH care. Rather, it is more associated with their greater demand for NH care, their lack of means to care for themselves in community settings, and the nature of Medicaid coverage.

Health Care Services Utilization

NH residents are heavy users of all types of health care services. They use more types of health care services and more expensive services than other Medicare beneficiaries, such as inpatient hospital, emergency room services, and extensive rehabilitation services. Figure 5-8 presents user rates by type of service for NH residents in 1995. Twenty-eight percent of them had at least one inpatient hospital stay in 1995, compared with approximately 18 percent of the community-only residents. Ninety-seven percent of them had at least one medical provider visit, and many of these visits involved a medical procedure or therapy. Over 80 percent of them received at least one medical procedure, and about one-half of them received services from therapists. In addition, one-third of them had at least one emergency room visit, and one-third of them received services from mental health care professionals.

Figure 5-8 User Rates for Nursing Home Residents by Type of Service, 1995



The medical services received by NH residents mostly reflect their health and health care needs. However, the expenditures also indicate problems inherent in the funding of acute care by one program and long-term care by another program. Medicare covers acute care, such as post-operative skilled nursing facility care, medically required short- or long-term home health care, and medical services in NHs. Medicaid, on the other hand, funds NH care and other noncovered services for NH residents who are eligible for both Medicare and Medicaid. Since Medicare is a Federal program and Medicaid is largely operated through states, this structure tends to create incentives for cost-shifting in the long-term care system (Feingold, 1997; Mitchell, 1997). Critics have commented on the Federal "retrenchment," and state and local governments' increased discretion and "devolution of responsibility" in terms of long-term care (Estes and Linkins, 1997).

The lack of coordination between Medicare and Medicaid programs causes unnecessary or inappropriate use of services by patients. These problems often have costly ramifications for public health resources. They may also result in inadequate care or no care at all for needy patients, in spite of seemingly high utilization rates. Examples of inappropriate use of acute care services include beneficiaries using home health care services as a substitute for treating chronic problems, and beneficiaries incurring extra inpatient days while waiting for NH placement (Ettner, 1993; Moon, 1997).

Critics maintain that if better primary care services could be provided to NH residents, it might help to reduce costly inappropriate hospital inpatient and ER use (Fama and Fox, 1997). However, there is no consensus on how to achieve this coordination. As long-term care, including NH care, is shifting subtly from a "means-tested" benefit to a universal entitlement, critics are debating whether Medicare should expand its coverage of NH care, even at a time when Medicare already extends its coverage to a number of medically related long-term care benefits, such as home nursing visits, physical therapy, and health aids (Kronenfeld, 1993; Moon, 1997).

Summary

Although NH residents constitute 5 percent of the Medicare population, this group has a major impact on the nation's health care and social services delivery systems. In 1995, it consumed one-fourth of personal health care resources used by Medicare beneficiaries. Factors contributing to the high cost of care for NH residents include room, board, and other NH expenses (78 percent of NH residents' PHCE in 1995); higher-than-average medical care spending; and high expenses for beneficiaries near or at the end of life. Because of their health care needs, NH residents are heavy users of all types of health care services. Rapid growth in PHCE for the NH population is caused by increasing numbers of disabled and aged beneficiaries in need of NH care, and higher per capita expenditures.

A majority share of health care expenditures by NH residents is funded by public resources. In 1995, Medicare and Medicaid paid 60 percent of PHCE by NH residents. Households, on the other hand, financed 30 percent of their PHCE. Per capita out-of-pocket payments for NH expenses alone amounted to $10,185 in 1995.

A typical NH resident is an elderly white female with severe functional disability, limited income, and low educational attainment. In 1995, more than 90 percent of NH residents had moderate to severe functional disabilities. Racial and ethnic minorities are under-represented in the NH population (12 percent); whereas dual eligibles are over-represented in the NH population (75 percent). A typical NH resident is likely to stay in a facility until the end of her life. Each year, approximately 30 percent of NH residents are discharged from long-term care facilities, and over one-half of the "discharges" have died in the facility. Because of high mortality and morbidity rates, NHs are places of high turnover.

Medicaid distorts the demand for and supply of NH beds. Medicaid's coverage of a majority share of NH expenses, and state-enforced, lower-than-market reimbursement rates and limits on the supply of NH beds cause excess demand for NH care by Medicaid eligibles. The excess demand for NH care can adversely affect access to care by dual eligibles and persons in need of chronic care. Other policy issues faced by this population include better coordination of acute and long-term care services.